

<i>SERFF Tracking Number:</i>	<i>SHEN-125832949</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Shenandoah Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>40413</i>
<i>Company Tracking Number:</i>	<i>GDENCS-8/08</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>Cosmetic Expense Rider</i>		
<i>Project Name/Number:</i>	<i>/</i>		

## Filing at a Glance

Company: Shenandoah Life Insurance Company

Product Name: Cosmetic Expense Rider

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Filing Type: Form

SERFF Tr Num: SHEN-125832949 State: ArkansasLH

SERFF Status: Closed

Co Tr Num: GDENCS-8/08

Co Status:

Author: Thomas Mason

Date Submitted: 10/01/2008

State Tr Num: 40413

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 10/02/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 10/02/2008

State Status Changed: 10/02/2008

Corresponding Filing Tracking Number:

Filing Description:

Re: GDENCS-8/08 - Cosmetic Expense Rider

GDENOR-8/08 - Orthodontic Expense Rider

Form 6003-8/08 - Accumulated Rollover Benefit Endorsement

Form 5788-Rev. 8/08 - True Dental Supplement

Form 5789-Rev. 8/08 - Voluntary Dental Supplement

Revised Policy Schedule Pages for GDENP-12/05 and PPOP-12/06

Revised Certificate Schedule Pages for GDENC-12/05 and PPOC-12/06

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer

Deemer Date:

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The captioned forms are filed herewith for approval by your Department. These forms are new and will not replace any currently on file with your Department, except the captioned dental supplement forms will replace the 12/06 versions approved August 16, 2008.

GDENCS-8/08 is an optional cosmetic expense rider providing covered cosmetic benefits for eligible insureds.

GDENOR-8/08 is an orthodontia benefit available for adults and/or dependent children.

Form 6003-8/08 is an accumulated rollover benefit endorsement which will provide participants who meet certain qualifying conditions a benefit to increase their annual benefit maximum in the subsequent policy year. This benefit is subject to accumulation up to a maximum amount.

Form 5788-Rev. 8/08 will supplement the multi-coverage base employer application Form 5787 Rev. 11/07 approved August 16, 2008 for the true group market of employer group sizes of 10+ employees, as well as any subsequently approved product.

Form 5789-Rev. 8/08 will supplement the multi-coverage base employer application Form 5787-Rev. 11/07 approved August 16, 2008 for a voluntary plan regardless of the group size, as well as any subsequently approved product.

The above riders and dental supplement forms will be used with Policy Form GDENP-12/05 approved January 5, 2006 and Policy Form PPOP-12/06 approved August 16, 2008, as well as any subsequently approved product.

Enclosed also are revised Policy and Certificate Schedule Pages for policy forms GDENP-12/05 and PPOP-12/06 and certificate forms GDENC-12/05 and PPOC-12/06 adding references for the Cosmetic Expense Rider and Accumulated Rollover Benefit Endorsement and modifying references for the new Orthodontic Expense Rider. Two versions of the policy schedule pages are being filed in order to support a phased approach to introducing the Cosmetic Benefit Package. Until system changes are made, the Schedule labeled "Accumulated Rollover ONLY" will be printed with the Policy and Certificate if (1) no orthodontia is selected; (2) child only orthodontia is selected; or (3) adult and child orthodontia is selected where the same lifetime maximum applies to all insureds.

The Schedule labeled "Vanity Package & Accumulated Rollover" will be included with the Policy and Certificate if (1)

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Product Name: Cosmetic Expense Rider  
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adult only orthodontia is selected; or (2) adult and child orthodontia is selected where a different lifetime maximum applies for adults and children. Once the benefits choices are fully automated, use of the Schedule labeled "Accumulated Rollover ONLY" will be discontinued.

The following items are also enclosed to supplement this filing:

1. Actuarial Memoranda
2. Readability Certification
3. AR Certification of Compliance

We trust that you will be in a position to give this filing an early review. If you have any questions or need additional information, please contact me at the phone number or email address shown on this letter.

Sincerely,

Pamela N. Ferguson  
Director, Legal Services

Attachments

## Company and Contact

### Filing Contact Information

Pamela Ferguson, Director, Legal Services pam.ferguson@shenlife.com  
P.O. Box 12847 (800) 848-5433 [Phone]  
Roanoke, VA 24029 (540) 857-5987[FAX]

### Filing Company Information

Shenandoah Life Insurance Company	CoCode: 68845	State of Domicile: Virginia
2301 Brambleton Ave. SW	Group Code: 891	Company Type: Life and Health
P.O. Box 12847		
Roanoke, VA 24029	Group Name:	State ID Number:
(800) 848-5433 ext. [Phone]	FEIN Number: 54-0377280	
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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	\$50.00 per filing
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Shenandoah Life Insurance Company	\$50.00	10/01/2008	22852886

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TOI:	H10G Group Health - Dental	Sub-TOI:	H10G.000 Health - Dental
Product Name:	Cosmetic Expense Rider		
Project Name/Number:	/		

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/02/2008	10/02/2008

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<i>Product Name:</i>	<i>Cosmetic Expense Rider</i>		
<i>Project Name/Number:</i>	<i>/</i>		

## **Disposition**

Disposition Date: 10/02/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Company Tracking Number: GDENCS-8/08

TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental

Product Name: Cosmetic Expense Rider

Project Name/Number: /

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Actuarial Memoranda	Approved-Closed	No
Supporting Document	Readability Certification	Approved-Closed	Yes
Form	Cosmetic Expense Rider	Approved-Closed	Yes
Form	Orthodontic Expense Rider	Approved-Closed	Yes
Form	Accumulated Rollover Benefit	Approved-Closed	Yes
	Endorsement		
Form	True Dental Supplement	Approved-Closed	Yes
Form	Voluntary Dental Supplement	Approved-Closed	Yes
Form	Revised Policy Schedule Pages	Approved-Closed	Yes
Form	Revised Certificate Schedule Pages	Approved-Closed	Yes

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 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
 Product Name: Cosmetic Expense Rider  
 Project Name/Number: /

## Form Schedule

**Lead Form Number:** GDENCS-8/08

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GDENCS-8/08	Policy/Cont Cosmetic Expense ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			GDENCS.pdf
Approved-Closed	GDENOR-8/08	Policy/Cont Orthodontic Expense ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			GDENOR.pdf
Approved-Closed	Form 6003-8/08	Policy/Cont Accumulated ract/Fratern Rollover Benefit al Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			Form 6003.pdf
Approved-Closed	Form 5788-Rev. 8/08	Application/True Dental Enrollment Supplement Form	Initial			5788.pdf
Approved-Closed	Form 5789-Rev. 8/08	Application/Voluntary Dental Enrollment Supplement	Initial			5789.pdf

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 Company Tracking Number: GDENCS-8/08  
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 Product Name: Cosmetic Expense Rider  
 Project Name/Number: /

Form

Approved- Closed	GDENP- 12/05, PPOP- 12/06	Schedule Pages	Revised Policy Schedule Pages	Initial	Schedule of Benefits GDENP - Accumulated Rollover ONLY.pdf Schedule of Benefits GDENP - Vanity Package & Accumulated Rollover.pdf Schedule of Benefits PPOP - Accumulated Rollover ONLY.pdf Schedule of Benefits PPOP - Vanity Package & Accumulated Rollover.pdf Schedule of Benefits GDENC - Accumulated Rollover ONLY.pdf Schedule of Benefits GDENC - Vanity Package &
Approved- Closed	GDENC- 12/05, PPOC- 12/06	Schedule Pages	Revised Certificate Schedule Pages	Initial	

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Project Name/Number:	/		

Accumulated  
Rollover.pdf  
Schedule of  
Benefits  
PPOC -  
Accumulated  
Rollover  
ONLY.pdf  
Schedule of  
Benefits  
PPOC -  
Vanity  
Package &  
Accumulated  
Rollover.pdf



## **COSMETIC EXPENSE RIDER**

Shenandoah Life Insurance Company has issued this Rider as part of the Policy to which it is attached.

### **A. DEFINITIONS**

1. **COSMETIC BENEFITS** means the benefits provided under this Rider as set forth below.
2. **COSMETIC SERVICES** means the Cosmetic Services set forth in this Rider for which a benefit may be payable.
3. **DATE STARTED**, with respect to Cosmetic Service shall be as set forth in the Policy except that for Services which require treatment on more than one date, the Date Started shall mean the date on which the Service is first begun.
4. **LATE ENTRANT** means an individual eligible for coverage under this Rider who does not apply for coverage under the Rider within 31 days after he is first eligible to apply for such coverage.]

For all other definitions, please refer to Section II of the Policy.

### **B. ELIGIBILITY**

Cosmetic Benefits are provided for an Insured Person [who is 19 years of age or older on the date on which Cosmetic Service is Started (an "Eligible Insured Person")]. Cosmetic Benefits are payable only for Covered Cosmetic Services which are started after an [Eligible] Insured Person's Effective Date of Cosmetic Coverage (see Section C. below). If a Cosmetic Service is Started before the Effective Date of Cosmetic Coverage under this Rider, or before the conclusion of any Waiting Period for Cosmetic Coverage, then the entire Cosmetic Service will be ineligible for benefits. The Waiting Period, if any, for Cosmetic Coverage is set forth in the Schedule of Benefits.

### **C. EFFECTIVE DATE**

If this Rider is issued on the same date as the underlying Policy, an [Eligible] Insured Person's Effective Date of Cosmetic Coverage shall be coincident with the Insured Person's Effective Date as set forth in Section III. B. of the Policy. If the Rider is issued after the Policy Effective Date, the [Eligible] Insured Person's Effective Date shall be the Insured Person's Effective Date in accordance with Section III.B. or the Effective Date of this Rider, whichever is later.

[If Employee's request for coverage under this Rider is received in the Home Office more than [31] days after he is first eligible to apply for such coverage, the [Eligible] Insured Person's coverage will take effect on the date on which Employee's request for coverage is received in the Home Office. However, Employee will be considered to be a Late Entrant and no benefits will be payable until coverage under this Rider has been in effect for [24] months].

### **D. EXTENSION/TERMINATION OF BENEFITS**

Cosmetic Benefits will be paid in accordance with Section VII of the Policy.

## COSMETIC EXPENSE RIDER

(Continued)

### E. COVERED COSMETIC SERVICES

The following is a complete list of those Cosmetic Services which will be considered for payment by Shenandoah Life. These services must be Started while insured and Completed while insured or as provided in Section B.

No payment will be made for any expense or any service not included in the list of Covered Cosmetic Services. A separate Coinsurance Rate, set forth in Section H applies.

A Lifetime Deductible Amount applies as set forth in Section K.

**Benefits are subject to the Waiting Period indicated in the Schedule of Benefits unless otherwise provided in this Rider.**

Benefits are payable for the actual charges, up to the maximum allowed by the Rider, incurred by an Insured Person for Covered Cosmetic Services performed by a Dentist. Benefits are payable only for amounts actually incurred for a Covered Cosmetic Service that has been completed while insured and following any applicable Waiting Period.

Benefits will be payable as defined in Section II. - Definitions under Benefit. Upon receipt of proof that an Insured Person has incurred an expense for a Covered Cosmetic Service, Shenandoah Life will determine benefits payable as follows:

#### [IN-NETWORK BENEFITS]

1. Determine the least of the Dentist's actual fee, the Negotiated Fee and the Scheduled Amount for each procedure;
2. Subtract the Lifetime Deductible amount for the applicable Insured Person. The Deductible will be applied to the claims in the order in which the claims are received by Shenandoah Life. If more than one claim is received on the same date, the deductible will be applied in chronological order according to the order in which the claims are processed by Shenandoah Life.
3. Multiply the result obtained in step 2 above by the applicable Coinsurance Rate set forth in Section H.
4. Any payment is subject to the Lifetime Maximum Benefit and all other Policy and Rider provisions.

**The [Eligible] Insured Person shall not be responsible for the difference between the Dentist's actual fee and the Negotiated Fee.]**

#### [[OUT-OF-NETWORK] BENEFITS]

1. Determine the least of the Dentist's actual fee, the [Prevailing Fee][Negotiated Fee] and the Scheduled Amount for each procedure;
2. Subtract the Lifetime Deductible amount for the applicable Insured Person. The Deductible will be applied to the claims in the order in which the claims are received by Shenandoah Life. If more than one claim is received on the same date, the deductible will be applied in chronological order according to the order in which the claims are processed by Shenandoah Life.
3. Multiply the result obtained in step 2 above by the applicable Coinsurance Rate set forth in Section H.
4. Any payment is subject to the Lifetime Maximum Benefit and all other Policy and Rider provisions.]

Under this Rider, Shenandoah Life will pay for certain Covered Cosmetic Services on a limited frequency. These limitations which apply to those Covered Cosmetic Services are indicated in the following Schedule of Covered Cosmetic Services.

## **COVERED COSMETIC SERVICES**

<b><u>Procedure</u></b>	<b><u>Limitation</u></b>	<b><u>Scheduled Amount</u></b>
[External Bleaching – per arch	Limited to one procedure per arch in any [36] consecutive month period	[\$250]
External Bleaching – per tooth	Limited to one procedure per tooth In any [36] consecutive month period	[\$40]
Internal Bleaching – per tooth	Limited to one procedure per tooth In any [36] consecutive month period. Benefits for internal bleaching will be based on the corresponding benefit for external bleaching.	[\$40]
Labial Veneer (resin laminate) – chairside	Covered only if more than [7] years have passed since the last placement	[\$400]
Labial Veneer (resin laminate)	Covered only if more than [7] years have passed since the last placement	[\$700]
Labial Veneer (porcelain laminate)	Covered only if more than [7] years have passed since the last placement	[\$850]

### **F. COINSURANCE**

The applicable Coinsurance Rate for Covered Cosmetic Services payable is [50%], subject to the Cosmetic Services Lifetime Maximum Benefit set forth in the Schedule of Benefits.

### **G. LIFETIME MAXIMUM BENEFIT**

The Lifetime Maximum Benefit payable under this Rider for Cosmetic Services for any [Eligible] Insured Person is the amount indicated on the Schedule of Benefits and applies individually to each [Eligible] Insured Person. The Lifetime Maximum Benefit will apply even if coverage is interrupted or if the Insured Person has been covered both as a Dependent and as an Employee. [The payment of Benefits under this Rider will be limited to the In-Network Lifetime Maximum Benefit indicated in the Schedule of Benefits. The In-Network Lifetime Maximum Benefit is inclusive of the Out-of-Network Lifetime Maximum Benefit; therefore, the difference between the Lifetime Maximum Benefit for In-Network services and the Lifetime Maximum Benefit for Out-of-Network services is available only for In-Network services.]

### **H. LIFETIME DEDUCTIBLE AMOUNT**

The Lifetime Deductible Amount shown in the Schedule of Benefits for this Rider is the amount of expense for Covered Cosmetic Services which must be paid in full on behalf of each Insured Person while this Rider is in force before any benefits are payable.

### **I. BENEFIT PAYMENT**

Cosmetic Services Benefits will be paid in accordance with Section VII. K and L of the Policy.

### **J. EXCLUSIONS**

The Exclusions set forth in Section XII of the Policy and Certificate do not apply. For the purposes of this Rider, Covered Cosmetic Services do not include and no benefits shall be payable under this Policy for procedures which are not included in the Schedule of Covered Services.

**K. CLAIMS**

The provisions set forth in Section VIII. of the Policy shall apply for all Claims made under this Rider.

**[L. CONTINUATION OF BENEFITS - CHILDREN AGE 19 AND OLDER**

If a Dependent Child is age nineteen (19) or older, Cosmetic Benefits will continue to be paid provided that:

1. The Cosmetic Service Started while the child was less than age nineteen (19) [but older than eighteen (18)] and the child was an eligible Dependent under the Policy; and
2. this Cosmetic Rider remains in force; and
3. the Child, except for age, continues to be an eligible Dependent under the Policy.]

**[M. SPECIAL REPLACEMENT PROVISIONS FOR GROUPS WITH PRIOR DENTAL COVERAGE**

If a Cosmetic Service was Started while the [Eligible] Insured Person was covered for substantially similar Cosmetic Benefits under the Replaced Policy and the Cosmetic Service is continued while the [Eligible] Insured Person is covered under the Policy and proof that the Lifetime Maximum under this Rider was not equaled or exceeded by the benefits paid or payable under the Replaced Policy is submitted to Shenandoah Life, then the Maximum Benefits for the [Eligible] Insured Person payable under this Rider will be calculated as follows:

1. Determine the lesser of the Maximum Benefit Payable under the Policy and this Rider and the Maximum Benefit Payable under the Replaced Policy;
2. Subtract the benefit paid or payable under the Replaced Policy from the result obtained above.

In no event will the [Eligible] Insured Person receive a greater cosmetic service benefit under the Policy and this Rider than the amount which he would have received had the Replaced Policy remained in effect.]



President

## ORTHODONTIC EXPENSE RIDER

Shenandoah Life Insurance Company has issued this Rider as part of the Policy to which it is attached.

### A. DEFINITIONS

1. **ADULT** means an Insured Person who is 19 years of age or older on the date on which Orthodontic Treatment is Started.
2. **ORTHODONTIC BENEFIT** means the benefits provided under this Rider.
3. **ORTHODONTIC TREATMENT** means the corrective movement of the teeth through the alveolar bone by means of an active appliance to correct a malocclusion of the mouth.
4. **STARTED**, with respect to Orthodontic Treatment means the date on which the bands or appliance(s) are first inserted. Any other treatment that can be completed on the same day as performed will be considered STARTED and completed on the actual date that the treatment is performed.

For all other definitions, please refer to Section II of the Policy.

### B. ELIGIBILITY

Orthodontic benefits are provided for an eligible [Insured Person] [Dependent Child who is under age 19 on the date on which Orthodontic Treatment is Started] [Adult]. Orthodontic Benefits are payable only for Covered Orthodontic Treatment which is started after an eligible [Insured Person's] [Dependent Child's] [Adult's] Effective Date of orthodontic coverage (see Section III. B. of the Policy). If Orthodontic Treatment is Started before the Effective Date of orthodontic coverage under this Rider, or before the conclusion of any Waiting Period for orthodontic coverage, then the entire Orthodontic Treatment plan will be ineligible for benefits. The Waiting Period, if any, for Orthodontic Coverage is set forth in the Schedule of Benefits.

### C. EXTENSION/TERMINATION OF BENEFITS

Orthodontic Benefits will be paid through the end of the quarter in which insurance for the person receiving treatment terminates for expenses Started while coverage is in force and for which the [Insured Person] [Dependent Child] [Adult] is liable, provided that the Policy remains in force.

### D. PREDETERMINATION OF BENEFITS

Before Orthodontic Treatment begins, a Treatment Plan must be submitted to Shenandoah Life. Shenandoah Life may request additional information as set forth in Subsection L. below. Shenandoah Life will notify the Employee and the Dentist of the benefits payable, if any, based on the Treatment Plan.

### E. COVERED ORTHODONTIC TREATMENT

Benefits are payable under this rider only for active Orthodontic Treatment and the ancillary services listed below. No benefits are payable for treatment intended to retain orthodontic relationships. Only the following services will be considered to be covered Orthodontic Treatment:

1. Cephalometric X-rays;
2. Diagnostic casts (i.e. study models) for orthodontic evaluation;
3. Fixed or removable orthodontic appliances for tooth movement and/or tooth guidance.

**ORTHODONTIC EXPENSE RIDER**

(Continued)

**F. COINSURANCE**

The percentage of covered Orthodontic Treatment payable is [100%], subject to the Lifetime Maximum Benefit set forth in the Schedule of Benefits.

**G. LIFETIME MAXIMUM BENEFIT**

The maximum lifetime benefit for any eligible [Insured Person] [Dependent Child] [and] [Adult] is the amount indicated on the Schedule of Benefits and applies individually to each covered [Insured Person] [Dependent Child] [and] [Adult]. The Lifetime Maximum Benefit will apply even if coverage is interrupted or if the [Insured Person] [Dependent Child] [or] [Adult] has been covered both as a Dependent and as an Employee.

**H. DETERMINATION OF MAXIMUM BENEFIT PAYABLE**

Upon receipt of appropriate proof of loss that an eligible [Insured Person] [Dependent Child who is 18 years old or younger] [Adult] has incurred covered orthodontic expenses while insured, Shenandoah Life will calculate the maximum benefit payable as follows:

1. Determine the lesser of the Prevailing Fee and the Dentist's actual fee;
2. Multiply by the appropriate Coinsurance. The payment will be subject to the Lifetime Maximum Benefit as stated above.

[Benefits will be based on the lesser of the Prevailing Fee and the Dentist's actual fee, regardless of any Negotiated Fees. The insured Person shall be responsible for the difference between the dentist's fee and any benefit payable under this Rider.]

**I. BENEFIT PAYMENT**

Orthodontic Benefits are paid in eight (8) equal quarterly installments. The amount of the Orthodontic Benefit payment will be calculated by determining the Maximum Benefit Payable and dividing by eight (8). The initial payment will be payable as of the date on which the orthodontic appliances are first installed. The subsequent quarterly benefit payments will be made for as long as the coverage remains in force and the Employee submits proof to Shenandoah Life that the Orthodontic Treatment is continuing or has been completed.

**J. PROOF OF LOSS**

Shenandoah Life shall have the reasonable right to require any of the following to aid in the determination of the benefits payable under the Policy:

1. Cephalometric X-rays and analysis;
2. Study models; and
3. Completion of a brief questionnaire which will specify:
  - a. The degree of overjet, overbite, crowding and open bite;
  - b. Whether the teeth are impacted, in crossbite, or congenitally missing;
  - c. The length of treatment;
  - d. The total charge for treatment.

**ORTHODONTIC EXPENSE RIDER**

(Continued)

**K. SPECIAL REPLACEMENT PROVISIONS FOR GROUPS WITH PRIOR DENTAL COVERAGE**

If Orthodontic Treatment was Started while the [Insured Person] [Dependent Child] [Adult] was covered for Orthodontic Benefits under the Replaced Policy and Orthodontic Treatment is continued while the [Insured Person] [Dependent Child] [Adult] is covered under the Policy and proof that the lifetime maximum under the Policy was not equaled or exceeded by the benefits paid or payable under the Replaced Policy is submitted to Shenandoah Life, then the benefits for the [Insured Person] [Dependent Child][Adult] payable under the Policy will be calculated as follows:

1. Determine the lesser of the Maximum Benefit Payable under the Policy and this Rider and the Maximum Benefit Payable under the Replaced Policy;
2. Subtract the benefit paid or payable under the Replaced Policy from the result obtained above.

In no event will the [Insured Person] [Dependent Child] [Adult] receive a greater orthodontic benefit under the Policy than the amount which he would have received had the Replaced Policy remained in effect.

**L. EXCLUSIONS AND LIMITATIONS**

In addition to the General Exclusions and Limitations of the Policy, Orthodontia Covered Charges will not include charges:

1. for any Services payable under any other provisions of the Policy[; or]
- [2. incurred by a Dependent Child age nineteen (19) or over on the date Orthodontia Services were Started; or]
- [3. incurred by Employee or his Spouse] [incurred by a Dependent Child].]

**[M. LIFETIME DEDUCTIBLE AMOUNT**

The Lifetime Deductible Amount shown in the Schedule of Benefits for this Rider is the amount of Covered Orthodontic Treatment which must be paid in full by Employee while this Rider is in force for each covered member of Employee's family before any benefits are payable.]

**[N. CONTINUATION OF BENEFITS - CHILDREN AGE 19 AND OLDER**

If a Dependent Child is age nineteen (19) or older, Orthodontic Benefits will continue to be paid provided that:

1. The Orthodontic Treatment Started while the child was less than age nineteen (19) and was an eligible Dependent under the Policy; and
2. Orthodontic Treatment continues; and
3. this Orthodontic Rider remains in force; and
4. the Child, except for age, continues to be an eligible Dependent under the Policy.]



President

## ACCUMULATED ROLLOVER BENEFIT ENDORSEMENT

Shenandoah Life Insurance Company has issued this Endorsement as part of the Policy to which it is attached.

### A. DEFINITIONS

1. **ROLLOVER AMOUNT** means the amount which may be added to the Accumulated Rollover Benefit for a [Calendar Year][Policy Year] under the terms and conditions set forth in this Endorsement. The amount is set forth in the Policy Schedule of Benefits.
2. **ACCUMULATED ROLLOVER BENEFIT** is the benefit established for each Insured Person which will be added to the Annual Maximum Benefit in the calculation of the Benefit payable on behalf of an Insured Person for Covered Services under this Policy.
3. **MAXIMUM ACCUMULATED ROLLOVER BENEFIT** is the maximum amount which may be accumulated by the Insured as his/her Accumulated Rollover Benefit. The amount is set forth in the Policy Schedule of Benefits.
4. **ANNUAL BENEFIT THRESHOLD** means the maximum amount of the total of all claims for Covered Services paid for the Insured Person in a Qualifying Year. The amount is set forth in the Policy Schedule of Benefits.
5. **QUALIFYING YEAR** means the [Calendar][Policy] Year in which the Insured Person qualifies for a Rollover Amount to be applied to the Annual Maximum Benefit for the following [Calendar][Policy] Year.

For all other definitions, please refer to Section II of the Policy.

- B. The following is added to Section VII.- BENEFITS, Subsection E. ANNUAL MAXIMUM BENEFIT of the Policy:

If an Insured Person meets all of the Qualifying Conditions in the Qualifying Year, the Insured Person shall earn a Rollover Amount. In the first year an Insured Person qualifies for the Rollover Amount, the amount of the Insured Person's Accumulated Rollover Benefit for the next [Calendar] [Policy] Year shall equal the Rollover Amount. At the end of each [Calendar] [Policy] Year, the Year End Rollover Benefit will be calculated by subtracting any claims paid in excess of the [In-Network and Out-of-Network] Annual Maximum Benefit[s] in the [Calendar][Policy] from the Accumulated Rollover Benefit at the beginning of that [Calendar] [Policy] Year. For each year in which the Insured Person meets the Qualifying Conditions, a Rollover Amount will be added to the Year End Accumulated Rollover Benefit until such Accumulated Rollover Benefit equals the Maximum Accumulated Rollover Benefit. In no event shall the amount in the Accumulated Rollover Benefit ever exceed the Maximum Accumulated Rollover Benefit.

In the event that after the Insured Person meets the Qualifying Conditions the Insured Person does not remain continuously covered under this Policy for any period of time [or in the event no claims for Covered Services are paid for an Insured Person in a [Calendar Year][Policy Year] ] all Rollover Amounts shall be forfeited immediately [upon the termination of coverage] and the Accumulated Rollover Benefit shall be zero.

### C. QUALIFYING CONDITIONS

In order for an Insured Person to qualify for the Accumulated Rollover Benefit provided for in this Endorsement for the following [Calendar] [Policy] Year, all of the following conditions must be satisfied:

1. At least one claim for Covered Services is paid for the Insured Person during the Qualifying Year;
2. The total of all claims for Covered Services paid for the Insured Person in the Qualifying Year does not exceed the Annual Benefit Threshold set forth in the Policy Schedule of Benefits; [and]
3. The Insured Person was covered under the Policy as of the first day of the Qualifying Year; and
4. The Insured Person is not subject to any Type III or Late Entrant Waiting Periods under the Policy as of the first day of the Qualifying Year].

### D. BENEFIT PAYMENT

If an Insured Person has earned an Accumulated Rollover Benefit, Benefits payable under the Policy will be calculated in accordance with SECTION XII. of the Policy by substituting the sum of the Accumulated Rollover Benefit and the Annual Maximum Benefit for the applicable Annual Maximum Benefit.

### E. LIMITATION

The Accumulated Rollover Benefit provided for in this Endorsement does not apply to or increase the Lifetime Benefit Maximum Amounts for any Riders which may be a part of this Policy.



President



**SHENANDOAH LIFE  
INSURANCE COMPANY**

Post Office Box 12847 Roanoke Virginia 24029 (800) 848-5433 www.shenlife.com

## ▲ TRUE DENTAL SUPPLEMENT ▲

Annual Open Enrollment Period? ..... ☐ Yes ☐ No Under a Section 125 Plan? ..... ☐ Yes ☐ No

Election Period: From \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ for coverage effective \_\_\_\_ / \_\_\_\_

(31 day maximum unless matching Section 125 Plan)

### PLAN OPTIONS

Please choose Coinsurance Plan or Scheduled Plan:

☐ **Coinsurance Plan:**

**Active PPO** or **Passive PPO/Indemnity**  
**In-Network Out-of-Network**

Type I: ..... % ..... % ..... %

Type II: ..... % ..... % ..... %

Type III: ..... % ..... % ..... %

Out-of-Network Fee Basis: ..... ☐ Prevailing Fee ☐ Negotiated Fee

Percentile used to determine prevailing fee: ..... ☐ 80th ☐ 90th ☐ Other \_\_\_\_\_

Category	Type		Waiting Period	
	<input type="checkbox"/> Standard	<input type="checkbox"/> Other	<input type="checkbox"/> Standard	<input type="checkbox"/> Other
Preventive Services: .....	Type I	Type ____	None	_____
Diagnostic Services: .....	Type I	Type ____	None	_____
Basic Restorative: .....	Type II	Type ____	None	_____
Non-Surgical Extractions: .....	Type II	Type ____	None	_____
Adjunctive General Services: .....	Type II	Type ____	None	_____
Complex Oral Surgery: .....	Type II	Type ____	None	_____
Endodontics: .....	Type II	Type ____	None	_____
Non-Surgical Periodontics: .....	Type II	Type ____	None	_____
Surgical Periodontics: .....	Type II	Type ____	None	_____
Major Restorative: .....	Type III	Type ____	12 months	_____
Adjustments and Repairs: .....	Type III	Type ____	12 months	_____

☐ **Scheduled Plan:** ☐ Standard Schedule ☐ Other (specify) \_\_\_\_\_

### BENEFIT OPTIONS

**Annual Maximum Benefit:** ..... ☐ Per Policy Year ☐ Per Calendar Year

Active PPO: ..... \$ \_\_\_\_\_ In-Network \$ \_\_\_\_\_ Out-of-Network

Passive PPO/Indemnity: ..... \$ \_\_\_\_\_

Accumulated Rollover Benefit: ..... ☐ Yes ☐ No

#### Deductible Options:

Deductible Amount:

Active PPO: ..... \$ \_\_\_\_\_ In-Network \$ \_\_\_\_\_ Out-of-Network

Passive PPO/Indemnity: ..... \$ \_\_\_\_\_

Deductible Type: ..... ☐ Per Policy Year ☐ Per Calendar Year ☐ Lifetime (N/A on Scheduled Plan)

Family Maximum Deductible: ..... ☐ 2 family members ☐ 3 family members ☐ No Maximum

*Scheduled Plan must choose no maximum*

Deductible waived for: ..... ☐ Preventive and Diagnostic ☐ Preventive only ☐ Not Waived

Deductible Credit for groups with prior dental coverage: ..... ☐ Yes ☐ No

**Orthodontia Benefits** (must have Major Restorative and Adjustments/Repairs to be eligible) – select one:

☐ Dependent Children only ☐ Adult(s) Only ☐ Dependent Children and Adult(s) ☐ None

**Orthodontia Lifetime Maximum Benefit:** ..... \$ \_\_\_\_\_ Dependent Children \$ \_\_\_\_\_ Adults

**Cosmetic Expense Lifetime Maximum Benefit:** ..... \$ \_\_\_\_\_

continued on reverse

**Employer contribution:** For employees: .....% For dependents (if applicable): .....%  
Number of employees eligible for coverage: ..... Number of employees enrolled: .....

**Does this policy replace existing or prior dental insurance?** ..... [ ] Yes [ ] No

If Yes, indicate: Name of carrier .....  
Effective date of prior coverage .....  
Proposed termination date of prior coverage .....  
Coverage being replaced: . [ ] Preventive [ ] Basic [ ] Major [ ] Orthodontia [ ] Cosmetic

If benefit waiting period credit is requested, the following items must be included with this application:

- complete copy of prior policy including group name, effective date, and schedule of benefits
- copy of most recent billing statement

Special Remarks .....

***All benefits and rates are subject to underwriting approval.***

It is understood and agreed that this application shall be made a part of the Policy applied for and that no insurance shall be effective until approved in writing by Shenandoah Life Insurance Company at its Home Office.

It is also recommended that no current dental insurance coverage be cancelled until Shenandoah Life Insurance Company approves this coverage in writing.

**Any person who, knowingly and with intent to defraud any insurance company or other persons, files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

*The following states require that alternate statements regarding insurance fraud be given. If you are a resident of any of the following states, please consider the following statements as replacements for the above statement.*

**Colorado** – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**New Jersey** – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Pennsylvania** – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Tennessee** – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Virginia** – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

**Florida** – Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Authorized Representative of Policyholder

Signature..... Date.....

Title .....

Agent

Signature..... Date.....

Print Name.....

(Florida agents must also show state license number) .....



**SHENANDOAH LIFE  
INSURANCE COMPANY**

Post Office Box 12847 Roanoke Virginia 24029 (800) 848-5433 www.shenlife.com

## ▲ VOLUNTARY DENTAL SUPPLEMENT ▲

☐ **Voluntary** (10+ eligible employees)

☐ **Voluntary** (2-9 eligible employees)

### ELIGIBILITY FOR ALL COVERAGES

Annual Open Enrollment Period? ..... ☐ Yes ☐ No Under a Section 125 Plan? ..... ☐ Yes ☐ No

Election Period: From \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ for coverage effective \_\_\_\_ / \_\_\_\_

(31 day maximum unless matching Section 125 Plan)

### VOLUNTARY SPECIFICATIONS FOR 10+ ELIGIBLE EMPLOYEES

*Please check plan, benefit type and benefit percentages you are selecting, if applicable.*

☐ **Coinurance Plan:**

	Active PPO		or	Passive PPO/Indemnity
	In-Network	Out-of-Network		
Type I: .....	_____ %	_____ %		_____ %
Type II: .....	_____ %	_____ %		_____ %
Type III: .....	_____ %	_____ %		_____ %
Type III: .....	<input type="checkbox"/> Full		<input type="checkbox"/> Limited	<input type="checkbox"/> None
Out-of-Network Fee Basis: .....	<input type="checkbox"/> Prevailing Fee		<input type="checkbox"/> Negotiated Fee	
Percentile used to determine prevailing fee: .....	<input type="checkbox"/> 80th		<input type="checkbox"/> 90th	<input type="checkbox"/> Other _____

Category	Type		Waiting Period		
	<input type="checkbox"/> Standard	<input type="checkbox"/> Other	<input type="checkbox"/> Option 1	<input type="checkbox"/> Option 2	<input type="checkbox"/> Other
Preventive Services: .....	Type I	Type ____	None	None	_____
Diagnostic Services: .....	Type II	Type ____	None	None	_____
Basic Restorative: .....	Type II	Type ____	None	None	_____
Non-Surgical Extractions: .....	Type II	Type ____	None	None	_____
Adjunctive General Services: .....	Type II	Type ____	None	None	_____
Complex Oral Surgery: .....	Type III	Type ____	12 months	12 months	_____
Endodontics: .....	Type III	Type ____	12 months	6 months	_____
Non-Surgical Periodontics: .....	Type III	Type ____	12 months	12 months	_____
Surgical Periodontics: .....	Type III	Type ____	12 months	12 months	_____
Major Restorative: .....	Type III	Type ____	12 months	24 months	_____
Adjustments and Repairs: .....	Type III	Type ____	12 months	12 months	_____

☐ **Graded Plan:**

	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>
Type I:	100%	100%	100%
Type II:	60%	70%	80%
Type III:	10%	30%	50%

☐ **Scheduled Plan**

continued on reverse

## VOLUNTARY SPECIFICATIONS FOR 10+ ELIGIBLE EMPLOYEES (Continued)

### BENEFIT OPTIONS

**Annual Maximum Benefit:** ..... [ ] Per Policy Year [ ] Per Calendar Year  
Active PPO: ..... \$\_\_\_\_\_ In-Network \$\_\_\_\_\_ Out-of-Network  
Passive PPO/Indemnity: ..... \$\_\_\_\_\_  
Accumulated Rollover Benefit: ..... [ ] Yes [ ] No

#### Deductible Options:

Deductible Amount:  
Active PPO: ..... \$\_\_\_\_\_ In-Network \$\_\_\_\_\_ Out-of-Network  
Passive PPO/Indemnity: ..... \$\_\_\_\_\_  
Deductible Type: ..... [ ] Per Policy Year [ ] Per Calendar Year [ ] Lifetime (*Coinsurance Only*)  
Family Maximum Deductible: ..... [ ] 2 family members [ ] 3 family members [ ] No Maximum  
*Scheduled and Graded Plans must choose no maximum*  
Deductible waived for: ..... [ ] Preventive and Diagnostic [ ] Preventive only [ ] Not Waived  
Deductible Credit for groups with prior dental coverage: ..... [ ] Yes [ ] No

**Orthodontia Benefits** (*must have Major Restorative and Adjustments/Repairs to be eligible*) – select one:

[ ] Dependent Children only [ ] Adult(s) Only [ ] Dependent Children and Adult(s) [ ] None

**Orthodontia Lifetime Maximum Benefit:** ..... \$\_\_\_\_\_ Dependent Children \$\_\_\_\_\_ Adults

**Cosmetic Expense Lifetime Maximum Benefit:** ..... \$\_\_\_\_\_

## VOLUNTARY SPECIFICATIONS FOR 2-9 ELIGIBLE EMPLOYEES

Annual Deductible: ..... [ ] \$25 [ ] \$50  
Annual Maximum: ..... [ ] \$750 [ ] \$1,000 [ ] \$1,200 [ ] \$1,500  
Coinsurance: ..... [ ] 100/80/0 [ ] 100/80/50 [ ] 100/90/60 IN, 100/80/50 OON  
Endodontics/Periodontics: ..... [ ] Type II [ ] Type III  
Benefit Basis: ..... [ ] 80th percentile [ ] 90th percentile [ ] Negotiated Fee  
Orthodontia: ..... [ ] \$0 [ ] \$750 [ ] \$1,000

*Annual deductible for Preventive Services (Type I) is waived.*

## TO BE COMPLETED FOR ALL COVERAGES

**Employer contribution:** For employees: ..... %  
For dependents (if applicable): ..... %  
Number of employees who are eligible for coverage: .....  
Number of employees enrolled: .....

**Does this policy replace existing insurance?** ..... [ ] Yes [ ] No

If Yes, indicate: Prior plan effective date \_\_\_\_\_  
Name of existing carrier \_\_\_\_\_  
Proposed termination date \_\_\_\_\_  
Coverage being replaced: .. [ ] Preventive [ ] Basic [ ] Major [ ] Orthodontia [ ] Cosmetic

If benefit waiting period credit is requested, the following items must be included with this application:

- copy of prior policy with group name, effective date, and schedule of benefits
- copy of most current billing statement

Special Remarks \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## TO BE COMPLETED FOR ALL COVERAGES

***All benefits and rates are subject to underwriting approval.***

It is understood and agreed that this application shall be made a part of the Policy applied for and that no insurance shall be effective until approved in writing by Shenandoah Life Insurance Company at its Home Office.

It is also recommended that no current dental insurance coverage be cancelled until Shenandoah Life Insurance Company approves this coverage in writing.

**Any person who, knowingly and with intent to defraud any insurance company or other persons, files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

*The following states require that alternate statements regarding insurance fraud be given. If you are a resident of any of the following states, please consider the following statements as replacements for the above statement.*

**Colorado** – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**New Jersey** – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Pennsylvania** – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Tennessee** – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Virginia** – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

**Florida** – Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Authorized Representative of Policyholder

Signature \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_

Agent

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

(Florida agents must also show state license number) \_\_\_\_\_

**SECTION I. - SCHEDULE OF BENEFITS**

**POLICY NUMBER:** [D000000001]  
**POLICYHOLDER:** [SPECIMEN]  
**POLICY EFFECTIVE DATE:** [December 01, 2005] at 12:01 A.M. at the Policyholder's address  
**PREMIUM DUE DATE:** [December 01, 2005 and the 1st day of each month thereafter]  
**POLICY ANNIVERSARY:** [December 01, 2006 and each December 01 thereafter]  
**ELIGIBLE CLASS(ES):**

Employees [All Actively at Work Employees]

[Spouse]

[Dependent Child(ren)]

[Retired Employees]

**ELIGIBILITY WAITING PERIOD:**

[Initial Employees] None]

[Subsequent Employees] 1st of the month following [90] days of continuous employment]

**MINIMUM REQUIREMENT FOR ACTIVE WORK**

[Working a minimum of [20] regularly scheduled hours per week.]

**CONTRIBUTORY INSURANCE**

Employee [No]

[Dependent Insurance] Yes]

[Retired Employees] Yes]

**COVERED SERVICES**

Type	Category	Coinsurance Rate	Waiting Period	Deductible Applies
[I]	Preventive Services	100%	None	No]
[I]	Diagnostic Services	100%	None	No]
[II]	Basic Restorative	80%	None	Yes]
[II]	Non-Surgical Extractions	80%	None	Yes]
[II]	Adjunctive General Services	80%	None	Yes]
[II]	Complex Oral Surgery	80%	None	Yes]
[II]	Endodontics	80%	None	Yes]
[II]	Non-Surgical Periodontics	80%	None	Yes]
[II]	Surgical Periodontics	80%	None	Yes]
[III]	Major Restorative	50%	12 months	Yes]
[III]	Adjustments/Repairs	50%	12 months	Yes]

[See Section VII.B. for explanation of waiting periods.]

[Waiting period credit will be awarded for all Initial Employees who had comparable coverage under the Replaced Policy and enroll for coverage commencing on the Effective Date of this Policy.] [Waiting period credit will be awarded for all Initial Employees who enroll for coverage commencing on the Effective Date of this Policy.] [The waiting periods are waived for all Initial Employees who enroll for coverage commencing on the Effective Date of this Policy.]

See Section XIII. for specific services.

**SECTION I. - SCHEDULE OF BENEFITS**

(Continued)

**ANNUAL MAXIMUM BENEFIT**

Annual Maximum Benefit for each Insured Person per [Policy] Year	[\$1,500]
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**DEDUCTIBLE**

[Deductible Amount for each Insured Person per [Policy] Year (Refer to Covered Services on page 3 to determine if the Deductible applies to certain services)	\$50]
--	-------

[Lifetime Deductible Amount for each Insured Person (Refer to Covered Services on page 3 to determine if the Deductible applies to certain services)	\$150]
--	--------

[Family Maximum Deductible	[3] Family Members]
----------------------------	---------------------

[Deductible credit	Yes]
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**[LATE ENTRANT LIMITATION**

[First 12 months]	[Covered Services limited to Type I] [Benefits limited to \$100]
-------------------	---

[Second 12 months]	[Covered Services limited to Type I and II] [Benefits limited to \$200]]
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**PREDETERMINATION OF BENEFITS**

Whenever the estimated cost of a recommended dental Treatment Plan exceeds [\$250.00], the Treatment Plan should be submitted to Shenandoah Life for its review before any treatment begins. See Section VII. E. for complete details.

**LIMITATIONS AND EXCLUSIONS**

Under this Policy, Shenandoah Life will pay for many Covered Services on a Limited Frequency. These limitations are indicated in Section XIII. - Schedule of Covered Services and Limitations. This Policy also contains specific Exclusions. See Section XII. for complete details.

**RIDERS**

Orthodontic Expense	[Yes]
[Adult Ortho	Yes]
[Waiting Period	12 months]
[Waiting Period Credit	Yes]
[Lifetime Maximum Benefit	\$1,000]
[Coinsurance Rate	50%]
[Lifetime Deductible Amount for each Insured Person	\$150]

[The waiting period may be reduced or waived for Insured Persons with prior coverage pursuant to Section XIV.]

**[SECTION I. - SCHEDULE OF BENEFITS**  
(Continued)

[Cosmetic Expense	[Yes]
[Lifetime Maximum Benefit for each Insured Person	[\$500]
[Waiting Period	12 months]
[Coinsurance Rate	50%]
[Lifetime Deductible Amount for each Insured Person	\$0]
[Late Entrant Limitation]	[Yes]

Eligibility: [All Insured Persons] [Eligible Insured Persons 19 years of age or older]

[The waiting period may be reduced or waived for Insured Persons with prior coverage pursuant to Section XIV.]]

**[ENDORSEMENT**

Accumulated Rollover Benefit	[Yes]
[Rollover Amount]	[\$250]
[Maximum Accumulated Rollover Benefit]	[\$1,000]
[Annual Benefit Threshold]	[\$500]

**SECTION I. - SCHEDULE OF BENEFITS**

**POLICY NUMBER:** [D000000002]  
**POLICYHOLDER:** [SPECIMEN]  
**POLICY EFFECTIVE DATE:** [December 01, 2005] at 12:01 A.M. at the Policyholder's address  
**PREMIUM DUE DATE:** [December 01, 2005 and the 1st day of each month thereafter]  
**POLICY ANNIVERSARY:** [December 01, 2006 and each December 01 thereafter]

**ELIGIBLE CLASS(ES):**

Employees [All Actively at Work Employees]  
 [Spouse]  
 [Dependent Child(ren)]  
 [Retired Employees]

**ELIGIBILITY WAITING PERIOD:**

[Initial Employees] None]  
 [Subsequent Employees] 1st of the month following [90] days of continuous employment]

**MINIMUM REQUIREMENT FOR ACTIVE WORK**

[Working a minimum of [20] regularly scheduled hours per week.]

**CONTRIBUTORY INSURANCE**

Employee [No]  
 [Dependent Insurance] Yes]  
 [Retired Employees] Yes]

**COVERED SERVICES**

Type	Category	Coinsurance Rate	Waiting Period	Deductible Applies
[I]	Preventive Services	100%	None	No]
[I]	Diagnostic Services	100%	None	No]
[II]	Basic Restorative	80%	None	Yes]
[II]	Non-Surgical Extractions	80%	None	Yes]
[II]	Adjunctive General Services	80%	None	Yes]
[II]	Complex Oral Surgery	80%	None	Yes]
[II]	Endodontics	80%	None	Yes]
[II]	Non-Surgical Periodontics	80%	None	Yes]
[II]	Surgical Periodontics	80%	None	Yes]
[III]	Major Restorative	50%	12 months	Yes]
[III]	Adjustments/Repairs	50%	12 months	Yes]

[See Section VII.B. for explanation of waiting periods.]

[Waiting period credit will be awarded for all Initial Employees who had comparable coverage under the Replaced Policy and enroll for coverage commencing on the Effective Date of this Policy.] [Waiting period credit will be awarded for all Initial Employees who enroll for coverage commencing on the Effective Date of this Policy.] [The waiting periods are waived for all Initial Employees who enroll for coverage commencing on the Effective Date of this Policy.]

See Section XIII. for specific services.

**SECTION I. - SCHEDULE OF BENEFITS**

(Continued)

**ANNUAL MAXIMUM BENEFIT**

Annual Maximum Benefit for each Insured Person per [Policy] Year	[\$1,500]
---	-----------

**DEDUCTIBLE**

[Deductible Amount for each Insured Person per [Policy] Year (Refer to Covered Services on page 3 to determine if the Deductible applies to certain services)	\$50]
--	-------

[Lifetime Deductible Amount for each Insured Person (Refer to Covered Services on page 3 to determine if the Deductible applies to certain services)	\$150]
--	--------

[Family Maximum Deductible	[3] Family Members]
----------------------------	---------------------

[Deductible credit	Yes]
--------------------	------

**[LATE ENTRANT LIMITATION**

[First 12 months]	[Covered Services limited to Type I] [Benefits limited to \$100]
-------------------	---

[Second 12 months]	[Covered Services limited to Type I and II] [Benefits limited to \$200]]
--------------------	---

**PREDETERMINATION OF BENEFITS**

Whenever the estimated cost of a recommended dental Treatment Plan exceeds [\$250.00], the Treatment Plan should be submitted to Shenandoah Life for its review before any treatment begins. See Section VII. E. for complete details.

**LIMITATIONS AND EXCLUSIONS**

Under this Policy, Shenandoah Life will pay for many Covered Services on a Limited Frequency. These limitations are indicated in Section XIII. - Schedule of Covered Services and Limitations. This Policy also contains specific Exclusions. See Section XII. for complete details.

**[SECTION I. - SCHEDULE OF BENEFITS**  
(Continued)

**[RIDERS**

Orthodontic Expense	[Yes]
[Lifetime Maximum Benefit	
[Dependent Children	[\$1,000]
[Adult	[\$1,000]]
[Waiting Period	12 months]
[Coinsurance Rate	50%]
[Lifetime Deductible Amount for each	
Insured Person	\$0]

[The waiting period may be reduced or waived for Insured Persons with prior coverage pursuant to Section XIV.]]

[Cosmetic Expense	[Yes]
[Lifetime Maximum Benefit for each Insured	
Person	[\$500]]
[Waiting Period	12 months]
[Coinsurance Rate	50%]
[Lifetime Deductible Amount for each	
Insured Person	\$0]
[Late Entrant Limitation]	[Yes]

Eligibility: [All Insured Persons] [Eligible Insured Persons 19 years of age or older]

[The waiting period may be reduced or waived for Insured Persons with prior coverage pursuant to Section XIV.]]

**[ENDORSEMENT**

Accumulated Rollover Benefit	[Yes]
[Rollover Amount]	[\$250]
[Maximum Accumulated Rollover Benefit]	[\$1,000]
[Annual Benefit Threshold]	[\$500]]

**SECTION I. - SCHEDULE OF BENEFITS**

**POLICY NUMBER:** [D000000001]  
**POLICYHOLDER:** [SPECIMEN]  
**POLICY EFFECTIVE DATE:** [January 01, 2007] at 12:01 A.M. at the Policyholder's address  
**PREMIUM DUE DATE:** [January 01, 2007 and the same day of each month thereafter]  
**POLICY ANNIVERSARY:** [January 01, 2008 and each January 01 thereafter]  
**ELIGIBLE CLASS(ES):**

Employees [All Actively at Work Employees]  
 [Spouse]  
 [Dependent Child(ren)]  
 [Retired Employees]

**ELIGIBILITY WAITING PERIOD:**

[Initial Employees] None]  
 [Subsequent Employees] 1st of the month following [90] days of continuous employment]

**MINIMUM REQUIREMENT FOR ACTIVE WORK**

[Working a minimum of [20] regularly scheduled hours per week.]

**CONTRIBUTORY INSURANCE**

Employee [No]  
 [Dependent Insurance] Yes]  
 [Retired Employees] Yes]

**COVERED SERVICES**

[Category]	Type		Coinsurance Rate*		Deductible Applies		Waiting Period	
	<u>In-Network</u>	<u>Out-of-Network</u>	<u>In-Network</u>	<u>Out-of-Network</u>	<u>In-Network</u>	<u>Out-of-Network</u>	<u>In-Network</u>	<u>Out-of-Network</u>
[Preventive Services]	I	I	100%	100%	No	Yes	None	None]
[Diagnostic Services]	I	I	100%	100%	No	Yes	None	None]
[Basic Restorative]	II	II	80%	70%	Yes	Yes	None	None]
[Non-Surg. Extractions]	II	II	80%	70%	Yes	Yes	None	None]
[Adjunctive Gen. Serv.]	II	II	80%	70%	Yes	Yes	None	None]
[Complex Oral Surgery]	II	II	80%	70%	Yes	Yes	None	None]
[Endodontics]	II	II	80%	70%	Yes	Yes	None	None]
[Non-Surg. Periodontics]	II	II	80%	70%	Yes	Yes	None	None]
[Surgical Periodontics]	II	II	80%	70%	Yes	Yes	None	None]
[Major Restorative]	III	III	50%	40%	Yes	Yes	None	12 months]
[Adjustments/Repairs]	III	III	50%	40%	Yes	Yes	None	12 months]

\* [In-Network percentage is applied to Negotiated Fee. Out-of-Network percentage is applied to [Prevailing Fee] [Negotiated Fee]].

[See Section VII.B. for explanation of waiting periods.]

[Waiting period credit will be awarded for all Initial Employees who had comparable coverage under the Replaced Policy and enroll for coverage commencing on the Effective Date of this Policy.] [Waiting period credit will be awarded for all Initial Employees who enroll for coverage commencing on the Effective Date of this Policy.] [The waiting periods are waived for all Initial Employees who enroll for coverage commencing on the Effective Date of this Policy.]

See Section XIII. for a complete list of Covered Services by specific procedure.

**SECTION I. - SCHEDULE OF BENEFITS**

(Continued)

**ANNUAL MAXIMUM BENEFIT**

	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum Benefit for each Insured Person per [Policy] Year	[\$1,500]	[\$1,000]

**DEDUCTIBLE**

	<u>In-Network</u>	<u>Out-of-Network</u>
[Deductible Amount for each Insured Person per [Policy] Year (Refer to Covered Services on page 3 to determine if the Deductible applies to certain services)]	\$50	\$100]
[Lifetime Deductible Amount for each Insured Person (Refer to Covered Services on page 3 to determine if the Deductible applies to certain services)]	\$150	\$250]
[Family Maximum Deductible	[3] Family Members	[3] Family Members]
[Deductible credit	Yes	Yes]

**[LATE ENTRANT LIMITATION**

[First 12 months]	[Covered Services limited to Type I] [Benefits limited to \$100]
[Second 12 months]	[Covered Services limited to Type I and II] [Benefits limited to \$200]]

**PREDETERMINATION OF BENEFITS**

Whenever the estimated cost of a recommended dental Treatment Plan exceeds [\$250], the Treatment Plan should be submitted to Shenandoah Life for its review before any treatment begins. See Section VII. F. for complete details.

**LIMITATIONS AND EXCLUSIONS**

Under this Policy, Shenandoah Life will pay for many Covered Services on a Limited Frequency. These limitations are indicated in Section XIII. - Schedule of Covered Services and Limitations. This Policy also contains specific Exclusions. See Section XII. for complete details.

**RIDERS**

	<u>[In-Network</u>	<u>Out-of-Network]</u>
Orthodontic Expense	[Yes]	[Yes]
[Adult Ortho	Yes	Yes]
[Waiting Period	12 months	24 months]
[Lifetime Maximum Benefit	\$1,500	\$1,000]
[Coinsurance Rate	50%	50%]
[Lifetime Deductible Amount for each Insured Person	\$150	\$150]

[The waiting period may be reduced or waived for Insured Persons with prior coverage pursuant to Section XIV.]

**[SECTION I. - SCHEDULE OF BENEFITS**

(Continued)

	<u>In-Network</u>	<u>Out-of-Network</u>
[Cosmetic Expense	[Yes]	[Yes]
[Lifetime Maximum Benefit for each Insured Person	[\$500]	[\$500]]
[Waiting Period	12 months	12 months]
[Coinsurance Rate	50%	50%]
[Lifetime Deductible Amount for each Insured Person	\$0	\$0]
[Late Entrant Limitation]	[Yes]	[Yes]

Eligibility: [All Insured Persons] [Eligible Insured Persons 19 years of age or older]

[The waiting period may be reduced or waived for Insured Persons with prior coverage pursuant to Section XIV.]]

**[ENDORSEMENT**

Accumulated Rollover Benefit	[Yes]
[Rollover Amount]	[\$250]
[Maximum Accumulated Rollover Benefit]	[\$1,000]
[Annual Benefit Threshold]	[\$500]]

**SECTION I. - SCHEDULE OF BENEFITS**

**POLICY NUMBER:** [D000000002]  
**POLICYHOLDER:** [SPECIMEN]  
**POLICY EFFECTIVE DATE:** [January 01, 2007] at 12:01 A.M. at the Policyholder's address  
**PREMIUM DUE DATE:** [January 01, 2007 and the same day of each month thereafter]  
**POLICY ANNIVERSARY:** [January 01, 2008 and each January 01 thereafter]

**ELIGIBLE CLASS(ES):**

Employees [All Actively at Work Employees]  
 [Spouse]  
 [Dependent Child(ren)]  
 [Retired Employees]

**ELIGIBILITY WAITING PERIOD:**

[Initial Employees] None]  
 [Subsequent Employees] 1st of the month following [90] days of continuous employment]

**MINIMUM REQUIREMENT FOR ACTIVE WORK**

[Working a minimum of [20] regularly scheduled hours per week.]

**CONTRIBUTORY INSURANCE**

Employee [No]  
 [Dependent Insurance] Yes]  
 [Retired Employees] Yes]

**COVERED SERVICES**

[Category]	Type		Coinsurance Rate*		Deductible Applies		Waiting Period	
	<u>In-Network</u>	<u>Out-of-Network</u>	<u>In-Network</u>	<u>Out-of-Network</u>	<u>In-Network</u>	<u>Out-of-Network</u>	<u>In-Network</u>	<u>Out-of-Network</u>
[Preventive Services]	I	I	100%	100%	No	Yes	None	None]
[Diagnostic Services]	I	I	100%	100%	No	Yes	None	None]
[Basic Restorative]	II	II	80%	70%	Yes	Yes	None	None]
[Non-Surg. Extractions]	II	II	80%	70%	Yes	Yes	None	None]
[Adjunctive Gen. Serv.]	II	II	80%	70%	Yes	Yes	None	None]
[Complex Oral Surgery]	II	II	80%	70%	Yes	Yes	None	None]
[Endodontics]	II	II	80%	70%	Yes	Yes	None	None]
[Non-Surg. Periodontics]	II	II	80%	70%	Yes	Yes	None	None]
[Surgical Periodontics]	II	II	80%	70%	Yes	Yes	None	None]
[Major Restorative]	III	III	50%	40%	Yes	Yes	None	12 months]
[Adjustments/Repairs]	III	III	50%	40%	Yes	Yes	None	12 months]

\* [In-Network percentage is applied to Negotiated Fee. Out-of-Network percentage is applied to [Prevailing Fee] [Negotiated Fee]].

[See Section VII.B. for explanation of waiting periods.]

[Waiting period credit will be awarded for all Initial Employees who had comparable coverage under the Replaced Policy and enroll for coverage commencing on the Effective Date of this Policy.] [Waiting period credit will be awarded for all Initial Employees who enroll for coverage commencing on the Effective Date of this Policy.] [The waiting periods are waived for all Initial Employees who enroll for coverage commencing on the Effective Date of this Policy.]

See Section XIII. for a complete list of Covered Services by specific procedure.

**SECTION I. - SCHEDULE OF BENEFITS**

(Continued)

**ANNUAL MAXIMUM BENEFIT**

	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum Benefit for each Insured Person per [Policy] Year	[\$1,500]	[\$1,000]

**DEDUCTIBLE**

	<u>In-Network</u>	<u>Out-of-Network</u>
[Deductible Amount for each Insured Person per [Policy] Year (Refer to Covered Services on page 3 to determine if the Deductible applies to certain services)]	\$50	\$100]
[Lifetime Deductible Amount for each Insured Person (Refer to Covered Services on page 3 to determine if the Deductible applies to certain services)]	\$150	\$250]
[Family Maximum Deductible	[3] Family Members	[3] Family Members]
[Deductible credit	Yes	Yes]

**[LATE ENTRANT LIMITATION**

[First 12 months]	[Covered Services limited to Type I] [Benefits limited to \$100]
[Second 12 months]	[Covered Services limited to Type I and II] [Benefits limited to \$200]]

**PREDETERMINATION OF BENEFITS**

Whenever the estimated cost of a recommended dental Treatment Plan exceeds [\$250], the Treatment Plan should be submitted to Shenandoah Life for its review before any treatment begins. See Section VII. F. for complete details.

**LIMITATIONS AND EXCLUSIONS**

Under this Policy, Shenandoah Life will pay for many Covered Services on a Limited Frequency. These limitations are indicated in Section XIII. - Schedule of Covered Services and Limitations. This Policy also contains specific Exclusions. See Section XII. for complete details.

**[SECTION I. - SCHEDULE OF BENEFITS**

(Continued)

**[RIDERS**

	<u>[In-Network</u> [Yes]	<u>Out-of-Network</u> [Yes]
Orthodontic Expense		
[Lifetime Maximum Benefit		
[Dependent Children	[\$1,000]	[\$1,000]]
[Adult	[\$1,000]	[\$1,000]]]
[Waiting Period	12 months	12 months]
[Coinsurance Rate	50%	50%]
[Lifetime Deductible Amount for each		
Insured Person	\$0	\$0]

[The waiting period may be reduced or waived for Insured Persons with prior coverage pursuant to Section XIV.]]

	<u>[In-Network</u> [Yes]	<u>Out-of-Network</u> [Yes]
[Cosmetic Expense		
[Lifetime Maximum Benefit for each Insured		
Person	[\$500]	[\$500]]
[Waiting Period	12 months	12 months]
[Coinsurance Rate	50%	50%]
[Lifetime Deductible Amount for each		
Insured Person	\$0	\$0]
[Late Entrant Limitation]	[Yes]	[Yes]

Eligibility: [All Insured Persons] [Eligible Insured Persons 19 years of age or older]

[The waiting period may be reduced or waived for Insured Persons with prior coverage pursuant to Section XIV.]]

**[ENDORSEMENT**

Accumulated Rollover Benefit	[Yes]
[Rollover Amount]	[\$250]
[Maximum Accumulated Rollover Benefit]	[\$1,000]
[Annual Benefit Threshold]	[\$500]]

**SECTION I. - SCHEDULE OF BENEFITS****POLICY NUMBER:** [D000000001 - 00001]**POLICYHOLDER:** [SPECIMEN]**[EMPLOYEE NAME:** JOHN DOE]**[CERTIFICATE NUMBER:** 0222334444]**[EMPLOYEE EFFECTIVE DATE:** December 01, 2005]**ELIGIBLE CLASS(ES):**

Employees [All Actively at Work Employees]

[Spouse]

[Dependent Child(ren)]

[Retired Employees]

**ELIGIBILITY WAITING PERIOD:**

[Initial Employees None]

[Subsequent Employees 1st of the month following [90] days of continuous employment]

**MINIMUM REQUIREMENT FOR ACTIVE WORK**

[Working a minimum of [20] regularly scheduled hours per week.]

**CONTRIBUTORY INSURANCE**

Employee [No]

[Dependent Insurance Yes]

[Retired Employees Yes]

**COVERED SERVICES**

Type	Category	Coinsurance Rate	Waiting Period	Deductible Applies
[I]	Preventive Services	100%	None	No]
[I]	Diagnostic Services	100%	None	No]
[II]	Basic Restorative	80%	None	Yes]
[II]	Non-Surgical Extractions	80%	None	Yes]
[II]	Adjunctive General Services	80%	None	Yes]
[II]	Complex Oral Surgery	80%	None	Yes]
[II]	Endodontics	80%	None	Yes]
[II]	Non-Surgical Periodontics	80%	None	Yes]
[II]	Surgical Periodontics	80%	None	Yes]
[III]	Major Restorative	50%	12 months	Yes]
[III]	Adjustments/Repairs	50%	12 months	Yes]

**[See Section VII.B. for explanation of waiting periods.]**

**[Waiting period credit will be awarded for all Initial Employees who had comparable coverage under the Replaced Policy and enroll for coverage commencing on the Effective Date of the Policy.] [Waiting period credit will be awarded for all Initial Employees who enroll for coverage commencing on the Effective Date of the Policy.]**

**[The waiting periods are waived for all Initial Employees who enroll for coverage commencing on the Effective Date of the Policy.]**

**See Section XII. for specific services.**

**SECTION I. - SCHEDULE OF BENEFITS**

(Continued)

**ANNUAL MAXIMUM BENEFIT**

Annual Maximum Benefit for each Insured Person per [Policy] Year	[\$1,500]
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**DEDUCTIBLE**

[Deductible Amount for each Insured Person per [Policy] Year (Refer to Covered Services on page 3 to determine if the Deductible applies to certain services)	\$50]
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[Lifetime Deductible Amount for each Insured Person (Refer to Covered Services on page 3 to determine if the Deductible applies to certain services)	\$150]
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[Family Maximum Deductible	[3] Family Members]
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[Deductible credit	Yes]
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**[LATE ENTRANT LIMITATION**

[First 12 months]	[Covered Services limited to Type I] [Benefits limited to \$100]
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[Second 12 months]	[Covered Services limited to Type I and II] [Benefits limited to \$200]]
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**PREDETERMINATION OF BENEFITS**

Whenever the estimated cost of a recommended dental Treatment Plan exceeds [\$250.00], the Treatment Plan should be submitted to Shenandoah Life for its review before any treatment begins. See Section VI. E. for complete details.

**LIMITATIONS AND EXCLUSIONS**

Under the Policy, Shenandoah Life will pay for many Covered Services on a Limited Frequency. These limitations are indicated in Section XII. - Schedule of Covered Services and Limitations. The Policy also contains specific Exclusions. See Section XI. for complete details.

**RIDERS**

Orthodontic Expense	[Yes]
[Adult Ortho	Yes]
[Waiting Period	12 months]
[Waiting Period Credit	Yes]
[Lifetime Maximum Benefit	\$1,000]
[Coinsurance Rate	50%]
[Lifetime Deductible Amount for each Insured Person	\$150]

[The waiting period may be reduced or waived for Insured Persons with prior coverage pursuant to Section XIII.]

**[SECTION I. - SCHEDULE OF BENEFITS**

(Continued)

[Cosmetic Expense	[Yes]
[Lifetime Maximum Benefit for each Insured Person	[\$500]
[Waiting Period	12 months]
[Coinsurance Rate	50%]
[Lifetime Deductible Amount for each Insured Person	\$0]
[Late Entrant Limitation]	[Yes]

Eligibility: [All Insured Persons] [Eligible Insured Persons 19 years of age or older]

[The waiting period may be reduced or waived for Insured Persons with prior coverage pursuant to Section XIV.]]

**[ENDORSEMENT**

Accumulated Rollover Benefit	[Yes]
[Rollover Amount]	[\$250]
[Maximum Accumulated Rollover Benefit]	[\$1,000]
[Annual Benefit Threshold]	[\$500]

**SECTION I. - SCHEDULE OF BENEFITS****POLICY NUMBER:** [D000000002 - 00001]**POLICYHOLDER:** [SPECIMEN]**[EMPLOYEE NAME:** JOHN DOE]**[CERTIFICATE NUMBER:** 0222334444]**[EMPLOYEE EFFECTIVE DATE:** December 01, 2005]**ELIGIBLE CLASS(ES):**

Employees [All Actively at Work Employees]

[Spouse]

[Dependent Child(ren)]

[Retired Employees]

**ELIGIBILITY WAITING PERIOD:**

[Initial Employees] None]

[Subsequent Employees] 1st of the month following [90] days of continuous employment]

**MINIMUM REQUIREMENT FOR ACTIVE WORK**

[Working a minimum of [20] regularly scheduled hours per week.]

**CONTRIBUTORY INSURANCE**

Employee [No]

[Dependent Insurance] Yes]

[Retired Employees] Yes]

**COVERED SERVICES**

Type	Category	Coinsurance Rate	Waiting Period	Deductible Applies
[I]	Preventive Services	100%	None	No]
[I]	Diagnostic Services	100%	None	No]
[II]	Basic Restorative	80%	None	Yes]
[II]	Non-Surgical Extractions	80%	None	Yes]
[II]	Adjunctive General Services	80%	None	Yes]
[II]	Complex Oral Surgery	80%	None	Yes]
[II]	Endodontics	80%	None	Yes]
[II]	Non-Surgical Periodontics	80%	None	Yes]
[II]	Surgical Periodontics	80%	None	Yes]
[III]	Major Restorative	50%	12 months	Yes]
[III]	Adjustments/Repairs	50%	12 months	Yes]

**[See Section VII.B. for explanation of waiting periods.]**

**[Waiting period credit will be awarded for all Initial Employees who had comparable coverage under the Replaced Policy and enroll for coverage commencing on the Effective Date of the Policy.] [Waiting period credit will be awarded for all Initial Employees who enroll for coverage commencing on the Effective Date of the Policy.]**

**[The waiting periods are waived for all Initial Employees who enroll for coverage commencing on the Effective Date of the Policy.]**

**See Section XII. for specific services.**

**SECTION I. - SCHEDULE OF BENEFITS**

(Continued)

**ANNUAL MAXIMUM BENEFIT**

Annual Maximum Benefit for each Insured Person per [Policy] Year	[\$1,500]
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**DEDUCTIBLE**

[Deductible Amount for each Insured Person per [Policy] Year (Refer to Covered Services on page 3 to determine if the Deductible applies to certain services)	\$50]
--	-------

[Lifetime Deductible Amount for each Insured Person (Refer to Covered Services on page 3 to determine if the Deductible applies to certain services)	\$150]
--	--------

[Family Maximum Deductible	[3] Family Members]
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[Deductible credit	Yes]
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**[LATE ENTRANT LIMITATION**

[First 12 months]	[Covered Services limited to Type I] [Benefits limited to \$100]
-------------------	---

[Second 12 months]	[Covered Services limited to Type I and II] [Benefits limited to \$200]]
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**PREDETERMINATION OF BENEFITS**

Whenever the estimated cost of a recommended dental Treatment Plan exceeds [\$250.00], the Treatment Plan should be submitted to Shenandoah Life for its review before any treatment begins. See Section VI. E. for complete details.

**LIMITATIONS AND EXCLUSIONS**

Under the Policy, Shenandoah Life will pay for many Covered Services on a Limited Frequency. These limitations are indicated in Section XII. - Schedule of Covered Services and Limitations. The Policy also contains specific Exclusions. See Section XI. for complete details.

**[SECTION I. - SCHEDULE OF BENEFITS**  
(Continued)

**[RIDERS**

Orthodontic Expense	[Yes]
[Lifetime Maximum Benefit	
[Dependent Children	[\$1,000]
[Adult	[\$1,000]]
[Waiting Period	12 months]
[Coinsurance Rate	50%]
[Lifetime Deductible Amount for each	
Insured Person	\$0]

[The waiting period may be reduced or waived for Insured Persons with prior coverage pursuant to Section XIV.]]

[Cosmetic Expense	[Yes]
[Lifetime Maximum Benefit for each Insured	
Person	[\$500]]
[Waiting Period	12 months]
[Coinsurance Rate	50%]
[Lifetime Deductible Amount for each	
Insured Person	\$0]
[Late Entrant Limitation]	[Yes]

Eligibility: [All Insured Persons] [Eligible Insured Persons 19 years of age or older]

[The waiting period may be reduced or waived for Insured Persons with prior coverage pursuant to Section XIV.]]

**[ENDORSEMENT**

Accumulated Rollover Benefit	[Yes]
[Rollover Amount]	[\$250]
[Maximum Accumulated Rollover Benefit]	[\$1,000]
[Annual Benefit Threshold]	[\$500]]

**SECTION I. - SCHEDULE OF BENEFITS**

**POLICY NUMBER:** [D000000001 - 00001]  
**POLICYHOLDER:** [SPECIMEN]  
**[EMPLOYEE NAME:** JOHN C DOE]  
**[CERTIFICATE NUMBER:** 0222334444]  
**[EMPLOYEE EFFECTIVE DATE:** January 01, 2007]  
**ELIGIBLE CLASS(ES):**  
 Employees [All Actively at Work Employees]  
 [Spouse]  
 [Dependent Child(ren)]  
 [Retired Employees]

**ELIGIBILITY WAITING PERIOD:**

[Initial Employees] None]  
 [Subsequent Employees] 1st of the month following [90] days of continuous employment]

**MINIMUM REQUIREMENT FOR ACTIVE WORK**

[Working a minimum of [20] regularly scheduled hours per week.]

**CONTRIBUTORY INSURANCE**

Employee [No]  
 [Dependent Insurance] Yes]  
 [Retired Employees] Yes]

**COVERED SERVICES**

[Category	Type		Coinsurance Rate*		Deductible Applies		Waiting Period	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
[Preventive Services	I	I	100%	100%	No	Yes	None	None]
[Diagnostic Services	I	I	100%	100%	No	Yes	None	None]
[Basic Restorative	II	II	80%	70%	Yes	Yes	None	None]
[Non-Surg. Extractions	II	II	80%	70%	Yes	Yes	None	None]
[Adjunctive Gen. Serv.	II	II	80%	70%	Yes	Yes	None	None]
[Complex Oral Surgery	II	II	80%	70%	Yes	Yes	None	None]
[Endodontics	II	II	80%	70%	Yes	Yes	None	None]
[Non-Surg. Periodontics	II	II	80%	70%	Yes	Yes	None	None]
[Surgical Periodontics	II	II	80%	70%	Yes	Yes	None	None]
[Major Restorative	III	III	50%	40%	Yes	Yes	None	12 months]
[Adjustments/Repairs	III	III	50%	40%	Yes	Yes	None	12 months]

\* [In-Network percentage is applied to Negotiated Fee. Out-of-Network percentage is applied to [Prevailing Fee] [Negotiated Fee]].

[See Section VI.B. for explanation of waiting periods.]

[Waiting period credit will be awarded for all Initial Employees who had comparable coverage under the Replaced Policy and enroll for coverage commencing on the Effective Date of the Policy.] [Waiting period credit will be awarded for all Initial Employees who enroll for coverage commencing on the Effective Date of the Policy.] [The waiting periods are waived for all Initial Employees who enroll for coverage commencing on the Effective Date of the Policy.]

See Section XII. for a complete list of Covered Services by specific procedure.

**SECTION I. - SCHEDULE OF BENEFITS**

(Continued)

**ANNUAL MAXIMUM BENEFIT**

	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum Benefit for each Insured Person per [Policy] Year	[\$1,500]	[\$1,000]

**DEDUCTIBLE**

	<u>In-Network</u>	<u>Out-of-Network</u>
[Deductible Amount for each Insured Person per [Policy] Year (Refer to Covered Services on page 3 to determine if the Deductible applies to certain services)]	\$50	\$100]
[Lifetime Deductible Amount for each Insured Person (Refer to Covered Services on page 3 to determine if the Deductible applies to certain services)]	\$150	\$250]
[Family Maximum Deductible	[3] Family Members	[3] Family Members]
[Deductible credit	Yes	Yes]

**[LATE ENTRANT LIMITATION**

[First 12 months]	[Covered Services limited to Type I] [Benefits limited to \$100]
[Second 12 months]	[Covered Services limited to Type I and II] [Benefits limited to \$200]]

**PREDETERMINATION OF BENEFITS**

Whenever the estimated cost of a recommended dental Treatment Plan exceeds [\$250], the Treatment Plan should be submitted to Shenandoah Life for its review before any treatment begins. See Section VI. F. for complete details.

**LIMITATIONS AND EXCLUSIONS**

Under the Policy, Shenandoah Life will pay for many Covered Services on a Limited Frequency. These limitations are indicated in Section XII. - Schedule of Covered Services and Limitations. The Policy also contains specific Exclusions. See Section XI. for complete details.

**RIDERS**

	<u>[In-Network</u>	<u>Out-of-Network]</u>
Orthodontic Expense	[Yes]	[Yes]
[Adult Ortho	Yes	Yes]
[Waiting Period	12 months	24 months]
[Lifetime Maximum Benefit	\$1,500	\$1,000]
[Coinsurance Rate	50%	50%]
[Lifetime Deductible Amount for each Insured Person	\$150	\$150]

[The waiting period may be reduced or waived for Insured Persons with prior coverage pursuant to Section XIII.]

**[SECTION I. - SCHEDULE OF BENEFITS**

(Continued)

	<u>In-Network</u>	<u>Out-of-Network</u>
[Cosmetic Expense	[Yes]	[Yes]
[Lifetime Maximum Benefit for each Insured Person	[\$500]	[\$500]]
[Waiting Period	12 months	12 months]
[Coinsurance Rate	50%	50%]
[Lifetime Deductible Amount for each Insured Person	\$0	\$0]
[Late Entrant Limitation]	[Yes]	[Yes]

Eligibility: [All Insured Persons] [Eligible Insured Persons 19 years of age or older]

[The waiting period may be reduced or waived for Insured Persons with prior coverage pursuant to Section XIII.]]

**[ENDORSEMENT**

Accumulated Rollover Benefit	[Yes]
[Rollover Amount]	[\$250]
[Maximum Accumulated Rollover Benefit]	[\$1,000]
[Annual Benefit Threshold]	[\$500]]

**SECTION I. - SCHEDULE OF BENEFITS**

**POLICY NUMBER:** [D000000002 - 00001]  
**POLICYHOLDER:** [SPECIMEN]  
**[EMPLOYEE NAME:** JOHN C DOE]  
**[CERTIFICATE NUMBER:** 0222334444]  
**[EMPLOYEE EFFECTIVE DATE:** January 01, 2007]  
**ELIGIBLE CLASS(ES):**  
 Employees [All Actively at Work Employees]  
 [Spouse]  
 [Dependent Child(ren)]  
 [Retired Employees]

**ELIGIBILITY WAITING PERIOD:**

[Initial Employees] None]  
 [Subsequent Employees] 1st of the month following [90] days of continuous employment]

**MINIMUM REQUIREMENT FOR ACTIVE WORK**

[Working a minimum of [20] regularly scheduled hours per week.]

**CONTRIBUTORY INSURANCE**

Employee [No]  
 [Dependent Insurance] Yes]  
 [Retired Employees] Yes]

**COVERED SERVICES**

[Category	Type		Coinsurance Rate*		Deductible Applies		Waiting Period	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
[Preventive Services	I	I	100%	100%	No	Yes	None	None]
[Diagnostic Services	I	I	100%	100%	No	Yes	None	None]
[Basic Restorative	II	II	80%	70%	Yes	Yes	None	None]
[Non-Surg. Extractions	II	II	80%	70%	Yes	Yes	None	None]
[Adjunctive Gen. Serv.	II	II	80%	70%	Yes	Yes	None	None]
[Complex Oral Surgery	II	II	80%	70%	Yes	Yes	None	None]
[Endodontics	II	II	80%	70%	Yes	Yes	None	None]
[Non-Surg. Periodontics	II	II	80%	70%	Yes	Yes	None	None]
[Surgical Periodontics	II	II	80%	70%	Yes	Yes	None	None]
[Major Restorative	III	III	50%	40%	Yes	Yes	None	12 months]
[Adjustments/Repairs	III	III	50%	40%	Yes	Yes	None	12 months]

\* [In-Network percentage is applied to Negotiated Fee. Out-of-Network percentage is applied to [Prevailing Fee] [Negotiated Fee]].

[See Section VI.B. for explanation of waiting periods.]

[Waiting period credit will be awarded for all Initial Employees who had comparable coverage under the Replaced Policy and enroll for coverage commencing on the Effective Date of the Policy.] [Waiting period credit will be awarded for all Initial Employees who enroll for coverage commencing on the Effective Date of the Policy.] [The waiting periods are waived for all Initial Employees who enroll for coverage commencing on the Effective Date of the Policy.]

See Section XII. for a complete list of Covered Services by specific procedure.

**SECTION I. - SCHEDULE OF BENEFITS**

(Continued)

**ANNUAL MAXIMUM BENEFIT**

	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum Benefit for each Insured Person per [Policy] Year	[\$1,500]	[\$1,000]

**DEDUCTIBLE**

	<u>In-Network</u>	<u>Out-of-Network</u>
[Deductible Amount for each Insured Person per [Policy] Year (Refer to Covered Services on page 3 to determine if the Deductible applies to certain services)]	\$50	\$100]
[Lifetime Deductible Amount for each Insured Person (Refer to Covered Services on page 3 to determine if the Deductible applies to certain services)]	\$150	\$250]
[Family Maximum Deductible	[3] Family Members	[3] Family Members]
[Deductible credit	Yes	Yes]

**[LATE ENTRANT LIMITATION**

[First 12 months]	[Covered Services limited to Type I] [Benefits limited to \$100]
[Second 12 months]	[Covered Services limited to Type I and II] [Benefits limited to \$200]]

**PREDETERMINATION OF BENEFITS**

Whenever the estimated cost of a recommended dental Treatment Plan exceeds [\$250], the Treatment Plan should be submitted to Shenandoah Life for its review before any treatment begins. See Section VI. F. for complete details.

**LIMITATIONS AND EXCLUSIONS**

Under the Policy, Shenandoah Life will pay for many Covered Services on a Limited Frequency. These limitations are indicated in Section XII. - Schedule of Covered Services and Limitations. The Policy also contains specific Exclusions. See Section XI. for complete details.

**[SECTION I. - SCHEDULE OF BENEFITS**

(Continued)

**[RIDERS**

	<u>[In-Network</u> [Yes]	<u>Out-of-Network</u> [Yes]
Orthodontic Expense		
[Lifetime Maximum Benefit		
[Dependent Children	[\$1,000]	[\$1,000]]
[Adult	[\$1,000]	[\$1,000]]]
[Waiting Period	12 months	12 months]
[Coinsurance Rate	50%	50%]
[Lifetime Deductible Amount for each		
Insured Person	\$0	\$0]

[The waiting period may be reduced or waived for Insured Persons with prior coverage pursuant to Section XIII.]]

	<u>[In-Network</u> [Yes]	<u>Out-of-Network</u> [Yes]
[Cosmetic Expense		
[Lifetime Maximum Benefit for each Insured		
Person	[\$500]	[\$500]]
[Waiting Period	12 months	12 months]
[Coinsurance Rate	50%	50%]
[Lifetime Deductible Amount for each		
Insured Person	\$0	\$0]
[Late Entrant Limitation]	[Yes]	[Yes]

Eligibility: [All Insured Persons] [Eligible Insured Persons 19 years of age or older]

[The waiting period may be reduced or waived for Insured Persons with prior coverage pursuant to Section XIII.]]

**[ENDORSEMENT**

Accumulated Rollover Benefit	[Yes]
[Rollover Amount]	[\$250]
[Maximum Accumulated Rollover Benefit]	[\$1,000]
[Annual Benefit Threshold]	[\$500]]

<i>SERFF Tracking Number:</i>	<i>SHEN-125832949</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Shenandoah Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>40413</i>
<i>Company Tracking Number:</i>	<i>GDENCS-8/08</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>Cosmetic Expense Rider</i>		
<i>Project Name/Number:</i>	<i>/</i>		

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: SHEN-125832949 State: Arkansas  
Filing Company: Shenandoah Life Insurance Company State Tracking Number: 40413  
Company Tracking Number: GDENCS-8/08  
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: Cosmetic Expense Rider  
Project Name/Number: /

## Supporting Document Schedules

**Satisfied -Name:** Certification/Notice **Review Status:** Approved-Closed 10/02/2008  
**Comments:**  
**Attachment:**  
ARCERT.pdf

**Bypassed -Name:** Application **Review Status:** Approved-Closed 10/02/2008  
**Bypass Reason:** Not applicable to this filing  
**Comments:**

**Satisfied -Name:** Readability Certification **Review Status:** Approved-Closed 10/02/2008  
**Comments:**  
**Attachment:**  
Readability Certification\_wo Emp App.pdf



TO: ARKANSAS DEPARTMENT OF INSURANCE

RE: **GDENCS-8/08 – Cosmetic Expense Rider**  
**GDENOR-8/08 – Orthodontic Expense Rider**  
**Form 6003-8/08 – Accumulated Rollover Benefit Endorsement**  
**Form 5788-Rev. 8/08 – True Dental Supplement**  
**Form 5789-Rev. 8/08 – Voluntary Dental Supplement**  
**Revised Policy Schedule Pages for GDENP-12/05 and PPOP-12/05**  
**Revised Certificate Schedule Pages for GDENC-12/05 and PPOC-12/05**

**CERTIFICATION OF COMPLIANCE**

I have reviewed or supervised the review of the policy forms contained in this filing and hereby certify that to the best of my knowledge and belief, the policy forms are in compliance with all laws, rules and regulations of the State of Arkansas, including Rule and Regulation 19 – Unfair Sex Discrimination in the Sale of Insurance, Rule and Regulation 49 – Life and Health Insurance Guaranty Association Notices, ACA 23-80-206 – Flesch Certification Minimum Standards, and Bulletin 11-88 – Consumer Information Notice.

*Kathleen M. Kronau*

\_\_\_\_\_  
(Signature of Company Officer)

Kathleen M. Kronau  
Vice President and General Counsel

\_\_\_\_\_  
Type Name & Title of Person Signing

October 1, 2008

\_\_\_\_\_  
Date

## READABILITY CERTIFICATION

This is to certify that the forms referenced below are in compliance with the readability requirements of your state.

The Flesch Reading Ease Test was applied to the forms.

FORM NUMBER	SENTENCES	WORDS	SYLLABLES	FLESH SCORE
GDENCS-8/08	63	978	1,422	68.1
GDENOR-8/08	58	816	1,300	57.8
Form 6003-8/08	25	414	537	80.2
Form 5788-Rev. 8/08	Scored with PPOP-12/06			51.6
Form 5789-Rev. 8/08	Scored with PPOP-12/06			51.8

*Kathleen M. Kronau*

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Signature of Company Officer

Kathleen M. Kronau  
Vice President and General Counsel

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Type Name & Title of Person Signing

September 17, 2008

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Date